PHYSICIAN CERTIFICATION FOR HYSTERECTOMY AND RECIPIENT ACKNOWLEDGEMENT OF STERILITY

ND DEPARTMENT OF HUMAN SERVICES

SFN 614 (Rev. 06-99)

a. I certify that prior to performing surgery I advised _____
(Name of Recipient)
both orally and in writing that the surgical procedure known as a hysterectomy would render her permanently sterile and that she would be incapable of reproducing children after the surgical procedure was completed.

Signature of Physician	Date

b. I certify that prior to the surgery, I received both orally and in writing information which explained that I would become permanently sterile and that I would be incapable of reproducing children after the hysterectomy was completed.

Signature of Recipient	Date

c. I certify that _____ was already sterile and unable to bear
(Name of Recipient)
children at the time the hysterectomy was performed.
The cause of sterility was _____

Signature of Physician	Date

d. I certify that the hysterectomy performed on _____
(Name of Recipient)
was completed under a life threatening emergency situation in which prior acknowledgement was not possible. The nature of the emergency was _____
_____

Signature of Physician	Date

ORIGINAL - Medical Services Unit
ND Department of Human Services
600 E Boulevard Ave - Dept 325
Bismarck ND 58505-0250

CANARY - Retained by Provider

(INSTRUCTIONS ON REVERSE SIDE)

INSTRUCTIONS FOR COMPLETION OF FORM

SECTION A - This section must be completed by the physician who is performing the hysterectomy. It is necessary to complete this section if the recipient will become sterile as a result of the surgical procedure and no life threatening circumstances existed at the time the procedure was performed. Enter the name of the recipient in the appropriate blank. The physician must sign and date the section. It is recommended, but not necessary, that this section be signed before the procedure was completed.

SECTION B - This section must be completed by the recipient, or her representative, who will become sterile and incapable of bearing children as a result of the hysterectomy. A signature in this section is not required if the recipient is already sterile or the hysterectomy was performed because of life threatening circumstances. It is recommended, but not necessary, that the recipient sign this section before the hysterectomy was rendered.

SECTION C - This section must be completed by the physician who performed a hysterectomy on a recipient who was already sterile at the time the hysterectomy procedure was rendered. Enter the name of the recipient in the appropriate blank. It is also necessary to state the reason for the sterility (post menopause, previous sterilization, etc.). The physician must also sign and date this section if appropriate.

SECTION D - This section must be completed by the physician who performed the hysterectomy when a life threatening circumstance prevented the physician from advising the recipient that the hysterectomy would result in sterility. The use of this section is limited to those situations where due to the condition of the recipient and the need for immediate surgery the physician was prevented from informing the recipient about the results of the surgery. This section cannot be used in situations where it could be anticipated that a hysterectomy may be performed such as non-emergency exploratory abdominal surgery.

Enter the name of the recipient. It is also necessary for the physician to state the nature of the emergency which prevented obtaining acknowledgement that the hysterectomy would render the recipient sterile. It is also required that the physician sign and date this section if appropriate.